PATIENT INFORMATION

NAME LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

DATE OF BIRTH: _____ AGE: _____ SS# _____ GENDER: M F

MARITAL STATUS: SINGLE, MARRIED, PARTNER, DIVORCED, WIDOWED # OF CHILDREN _____

OCCUPATION: _____ EMPLOYER: _____

EMAIL: _____

EMERGENCY CONTACT NAME _____ PHONE: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

FINANCIAL POLICY

Our practice is a fee for service practice. **Full payment is expected at the time of service**. You will receive a detailed insurance receipt that can be submitted to your insurance carrier. Approved BWC claims are exempt from day of service billing and will be billed at their accepted insurance rates. No third party auto insurance claims are accepted. We are non-participating Medicare providers meaning you will pay at time of service but Medicare will be billed for you. Medicare only covers adjustments of the spine.

Are you on Medicare? Y N If yes, please fill out required Medicare ABN form.

We accept cash, check, CC, FSA/HSA.

Our fees are as follows:

New Patient Exam (includes 1 treatment) $150 Re-exam $50

Acupuncture $70, Chiropractic $50, PT Modalities only $50

A $40 fee will be assessed for returned checks. A $40 fee will be assessed for No Show appointments.

I acknowledge that I am fully responsible for all charges incurred at Polaris Wellness.

Signature: _____

PRIVACY NOTICE AND HIPAA CONSENT

I consent to the use or disclosure of my personal health information for the purpose of diagnosing, treating, or obtaining payment. I have been given the opportunity to review the Notice of Privacy Practices.

Signature: _____ Date: _____

SYMPTOMS Reason for visit: _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Same ☐Better

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down ☐Other _____

Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other _____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain):

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night Only

Is there anything you can do to relieve the problem? ☐Yes ☐No If yes, describe, _____

Have you ever had the same or a similar condition? ☐Yes ☐No If yes, when, _____

List any major accidents you have had? _____

What treatment have you already received for your condition?

☐Medication ☐Surgery ☐Physical Therapy ☐Other _____

Name and address/phone numbers of other doctor(s) who have treated you for your condition:

_____

HEALTH HISTORY

Check only those conditions which are applicable:

☐AIDS/HIV	☐Cataracts	☐Hepatitis	☐Osteoporosis	☐Suicide Attempt
☐Alcoholism	☐Chemical Dependency	☐Hernia	☐Pacemaker	☐Thyroid Problems
☐Allergy Shots	☐Chicken Pox	☐Herniated Disc	☐Parkinson=s Disease	☐Tonsillitis
☐Anemia	☐Depression	☐Herpes	☐Pinched Nerve	☐Tuberculosis
☐Anorexia	☐Diabetes	☐High Cholesterol	☐Pneumonia	☐Tumors, Growths
☐Appendicitis	☐Emphysema	☐Kidney Disease	☐Polio	☐Typhoid Fever
☐Arthritis	☐Epilepsy	☐Liver Disease	☐Prostate Problems	☐Ulcers
☐Asthma	☐Fractures	☐Measles	☐Prosthesis	☐Vaginal Infections
☐Bleeding Disorders	☐Glaucoma	☐Migraine Headache	☐Psychiatric Care	☐Venereal Disease
☐Breast Lump	☐Goiter	☐Miscarriage	☐Rheumatoid Arthritis	☐Whooping Cough
☐Bronchitis	☐Gonorrhea	☐Mononucleosis	☐Rheumatic Fever	☐Other _____
☐Bulimia	☐Gout	☐Multiple Sclerosis	☐Scarlet Fever	_____
☐Cancer	☐Heart Disease	☐Mumps	☐Stroke	

Name of Family Physician: _____ May we contact: ☐Yes ☐No

Physician Phone Number & Address: _____

Date of last exams: _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

List any types of surgeries which you have had and the dates which they occurred:

_____

Please list all medications you are currently taking: _____

Allergies: _____

DAILY HABITS

What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ☐Yes ☐No How much per day? _____

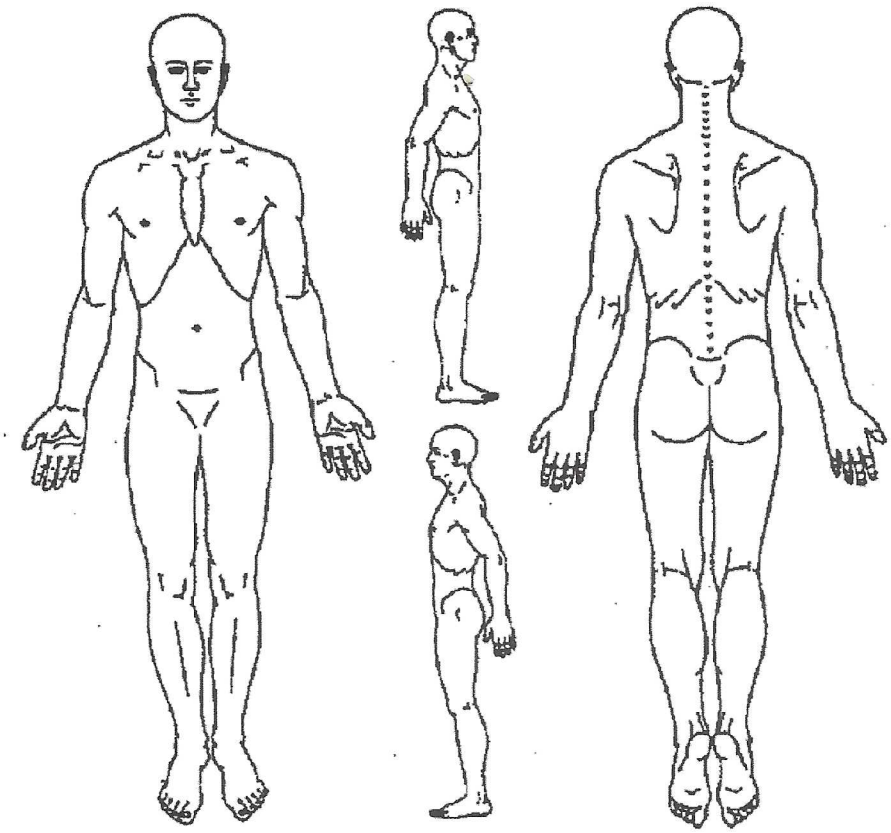
How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |——————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

Polaris Acupuncture & Chiropractic Center LLC
Dr. Shauna Hindman D.C., Dipl.Ac
110 County Line Road West, Suite B
Westerville, OH 43082

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic, acupuncture and/or related procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Shauna Hindman, D.C., Dipl.Ac. and /or other health professionals who are serving as back-up for Dr. Hindman.

I understand that methods or treatment may include, but are not limited to, chiropractic, acupuncture, electric stimulation, ultrasound, massage, hot or cold packs, traction, supplements/herbal medicine, and nutritional/lifestyle counseling. I have the opportunity to discuss with Dr. Hindman the nature and purpose of chiropractic or acupuncture treatment and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been rare instances reported in the literature of fainting, infections, scarring, spontaneous abortions, and pneumothorax. Dr. Hindman uses pre-sterilized, disposable needles exclusively in her practice. If I become pregnant, I will inform Dr. Hindman.

If I experience any gastro-intestinal upset or allergic reactions to the herbs/nutritional supplements I will inform Dr. Hindman.

Chiropractic care involves certain complications that include but are not limited to fracture, stroke, disc injury, dislocations, strains, stiffness, and soreness. These complications are rare and Dr. Hindman will make every reasonable effort during the exam to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. You may have other treatment options for your condition. These may include self-administered over the counter medicine and rest, medical care with prescriptions, hospitalization, or surgery.

I do not expect Dr. Hindman to be able to anticipate and explain all possible risks and complications. I wish to rely on her to exercise good judgment and to provide treatment regarding my best interests. I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my prior written consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo treatment recommended by Dr. Hindman. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I certify I understand what I have read and am of sound mind.

Signed_____ Date_____
Patient's Name_____ (please print)
Signature of Parent or Legal Guardian_____
Relationship to patient_____